

DIABETES Treatment Plan Recommendations

Monitor patients

▶ A1C <7%, Prefer <6% FPG 90-130mg/dl PP PG 140-180mg/dl	Recommended Q 3-6 months
▶ Blood Pressure <130/80	Each Visit
▶ Cholesterol/Lipid Control LDL <100mg/dl <70mg/dl with CVD HDL ♂ >40mg/dl ♀ >50mg/dl TG <150mg/dl	Annual
▶ Nephropathy Screening Serum Creatinine GFR Calculation Microalbuminuria	Annual Annual
▶ Weight	Each Visit
▶ Comprehensive Foot Exam Foot Sensitivity & PAD If insensate, q 3-6 months.	Annual Annual
▶ Autonomic Neuropathy	At Diagnosis & Annual
▶ TSH	Annual
▶ Dilated Eye Exam	Annual
▶ Immunizations Influenza Pneumonia	Annual 1/lifetime

Psychosocial assessment and care
Preconception counseling as indicated

If a patient is diagnosed with diabetes...

Take ACTION

- ▶ Treat **A1C** and **Blood Glucose** to target
Review patients Blood Glucose records and help them problem solve for improvement
- ▶ Treat **Blood Pressure** to target, ACE or ARB preferred. Initiate drug therapy if BP>140/90 in addition to lifestyle and behavioral therapy
- ▶ Treat **Cholesterol/Lipids** to target with lifestyle intervention including Medical Nutrition Therapy (MNT), physical activity, weight loss, smoking cessation, and medications
- ▶ Assess kidney function and need for treatment with ACE/ARB
Consider referral to nephrologists when GFR<60ml/min/1.73m²
- ▶ Consider Antiplatelet therapy for primary and secondary prevention of CVD events
- ▶ Promote Self-Management through lifestyle interventions to achieve healthy body weight, control BG, LIPIDS, and BP
- ▶ Recommend physical activity to improve glycemia, assist in weight management, and reduce CVD risk
150 minutes/week moderate and/or
90 minutes/week vigorous +resistance
- ▶ Teach self-foot care. Refer if high risk
- ▶ Assess and treat/refer for autonomic neuropathy symptoms
- ▶ Advise all patients not to smoke
- ▶ Provide cessation counseling and other forms of treatment
- ▶ Assist patient in setting behavior change goals that are something they want to do and are small, measurable, and achievable

FOLLOW-UP

- ▶ Schedule follow-up q 3-6 months until goals are met

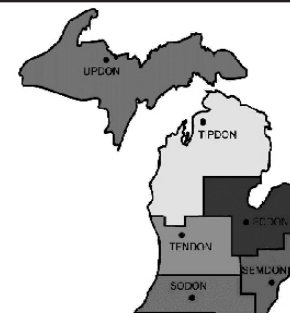
REFER

- ▶ Refer to Diabetes Self-Management Education Program when diagnosed and when needed
- ▶ Refer to MNT for individualized counseling
- ▶ Refer to specialists as indicated
- ▶ Refer to self-management support programs

Michigan Diabetes Outreach Networks (DONs)

www.diabetesinmichigan.org

ECDON — (810) 232-0522
TENDON — (616) 458-9520
SEMDON — (313) 259-1574
TIPDON — (800) 847-3665
SODON — (800) 795-7800
UPDON — (906) 228-9203



www.ndep.nih.gov



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PREDIABETES Treatment Plan Recommendations

Monitor patients for prediabetes

- ▶ FBS every 3 years for those 45 yrs and older
- ▶ FBS more frequently and/or at a younger age (<45 yrs) for overweight patients with additional risk* factors

American Diabetes Association Diagnosis Criteria

	FPG	OGTT 2hr
Euglycemia	60 – 99	60-139
Prediabetes	100-125	140-199
Type 2 Diabetes	≥126	≥200

*Risk factors for developing diabetes:

- Sedentary lifestyle
- First-degree relative with diabetes
- Overweight
- Race/ethnicity (African American, American Indian, Hispanic American/Latino, and Asian American/Pacific Islander)
- Gestational diabetes or delivery of baby weighing >9 lbs.
- Hypertension (≥140/90 mmHg)
- Low HDL cholesterol level <35 mg/dl and/or high triglyceride level >250mg/dl
- IFG or IGT on previous testing
- Polycystic ovary syndrome, history of vascular disease, other clinical conditions associated with insulin resistance

If a patient is diagnosed with prediabetes...

Take ACTION

- ▶ Recommend Lifestyle Modification for FPG 100-125mg/dl
- ▶ Weight loss – 5-7% weight loss will improve blood glucose levels
- ▶ Exercise – start slow, work up to 1 hour, 5 times a week
- ▶ Medication – as appropriate (both IFG and IGT abnormalities documented)
- ▶ Treat borderline and high blood pressure
- ▶ Treat borderline and high cholesterol
- ▶ Evaluate for stress and depression – treat or refer as appropriate
- ▶ Evaluate adequacy of sleep – treat sleep disorders
- ▶ Advise smokers to quit – treat or refer as appropriate

FOLLOW-UP

- ▶ Schedule routine appointments every 3-6 months until goals are met
- ▶ Continue to monitor for the development of diabetes every 1-2 years

REFER

Patients need ongoing information and support. Refer them to:

- ▶ Local diabetes self-management training programs for classes – check insurance for coverage
- ▶ Nutritional counseling – medical nutrition therapy – check insurance for coverage
- ▶ Diabetes Outreach Networks (DONs) for local information on training programs, local events, and resources

ICD-9 Codes Related to Prediabetes

V77.1	Lab code to be used if suspicious for Prediabetes (Screening for diabetes)	
790.2	Abnormal glucose	
790.21	Impaired Fasting Glucose (IFG)	FPG 100-125 mg/dl
790.22	Impaired Glucose Tolerance (IGT)	2-hour OGTT value 140-199 mg/dl
790.29	Other abnormal glucose	- Abnormal non-fasting glucose - Prediabetes, NOS (Not otherwise specified) - Abnormal glucose, NOS

CPT Codes Related to Prediabetes

82947	Glucose; quantitative, blood (except reagent strip)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)



**Diabetes Partners in Action
Coalition (DPAC)**
Prevention Workgroup

Reference

American Diabetes Association: Clinical Practice Recommendations 2008

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